| STATEMEN | T OF DEFICIENCIES | X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE CO | ONSTRUCTION | (X3) DATE SURVEY |
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| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A DUILDING | | COMPLETED |
| | | 155479 | A. BUILDING B. WING | | 02/28/2011 |
| | | | | ADDRESS, CITY, STATE, ZIP CODE | |
| NAME OF I | PROVIDER OR SUPPLIEF | ₹ | | V WASHINGTON CENTER ROA | ۱D |
| KINGSTO | ON CARE CENTER | OF FORT WAYNE | | WAYNE, IN46825 | |
| (X4) ID | SUMMARY S | STATEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF CORRECTION | (X5) |
| PREFIX | , i | ICY MUST BE PERCEDED BY FULL | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | |
| TAG | REGULATORY OR | LSC IDENTIFYING INFORMATION) | TAG | DEFICIENCY) | DATE |
| K0000 | A Life Safety Conducted by the Department of with 42 CFR 48 Survey Date: Conducted by the Department of with 42 CFR 48 Survey Date: Conducted by the Department of With 42 CFR 48 Survey Date: Conducted Surveyor: Amy Code Specialist At this Life Safe Kingston Care was found not Requirements Medicare/Medi 483.70(a), Life the 2000 edition Protection Associate Safety Code Existing Health the 100, 200 and compliance with Health Care Ochall, or with 410 departments of the Care Ochall, or with 410 department of the Care Ochall of the Care O | code Recertification and e Survey was he Indiana State Health in accordance 33.70(a). D2/28/11 Dr: 000522 Der: 155479 100267040 y Kelley, Life Safety | K0000 | Enclosed is the plan of correct for the Life Safety Survey completed at Kingston Care Center on 2/28/11. Please consider this the facility's cred allegation of compliance. However, submission of this response and plan of correction to a legal admission that a deficiency exists or that this Statement of Deficiency was correctly rendered, and is also to be constructed as an admission of interest against the facility, the administrator or an employees agent or other individuals who draft or may be discussed in this response and plan of correction. In addition preparation and submission of this plan of correction does not constitute an admission or agreement of any conclusions forth in the allegation by the survey agency. Rather, this pof correction has been preparabecause the law requires us to prepare a plan of correction for the citations regardless of whether we agree with them. | tion lible on is o not the ny ee d f ot s set |
| | to be of Type V | facility was determined (111) construction and klered. The facility has | | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

4VNL21

Facility ID:

000522

TITLE

If continuation sheet

| | STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155479 | | (X2) MULTIPLE CO A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 02/28/2011 | | |
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| | PROVIDER OR SUPPLIER | | STREET ADDRESS, CITY, STATE, ZIP CODE 1010 W WASHINGTON CENTER ROAD FORT WAYNE, IN46825 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY) | (X5) COMPLETION DATE | |
| K0021 SS=E | a fire alarm systetction in the to the corridors on 400 hall. Si operated smok installed in all r 200 and 300 had capacity of 120 114 at the time. Quality Review by 1 Safety Code Special 03/07/11. The facility was compliance with regulatory required by the following. Based on obsetthe facility failed down doors at kitchen wall, a self close upon alarm system. | tem with smoke corridors, areas open and all resident rooms ngle station battery e detectors have been esident rooms on 100, alls. The facility has a and had a census of of this survey. Robert Booher, REHS, Life ist-Medical Surveyor on found not in the aforementioned irements as evidenced | K0021 | Facility contracted with a veno to install a relay connected to alarm system to atomatically close the rolling fire door wher fire alarm system is activated. | fire | |
| | hall dining room Findings includ | | | | | |
| | | ector on 02/28/11 at | | | | |

| | STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) MULTIPLE CO | ONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | | 155479 | A. BUILDING B. WING | | 02/28/2011 |
| | PROVIDER OR SUPPLIER | | 1010 V | ADDRESS, CITY, STATE, ZIP CODE V WASHINGTON CENTER ROA WAYNE, IN46825 | D |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY) | (X5) COMPLETION DATE |
| | was open to the requirements for allowed to be on the wall around therefore, consider corridor wall. If through opening between the direction with a rolling firm link. Based on Staff # 1 at the the rolling firm of the rolling firm was acknowled Director at the test of the state | e 400 hall dining room e corridor and met the or a space to be pen to the corridor. d the dining room is idered to be the There was a pass g in the corridor wall ning room and the pening was protected e door with a fusible interview with Kitchen time of observation, loor does not close of the fire alarm. This iged by the Operations time of observation. | | | |
| K0038 SS=E | the facility failed accesses from readily accessil accordance wit LSC Section 7. egress for new with Chapter 7. requires a ramp than 6 inches s both sides. This could affect res | rvation and interview, d to ensure 1 of 3 exit the 400 hall was ble at all time in h LSC Section 7.1. 1 requires means of buildings shall comply LSC Section 7.2.5.4 b with a rise greater hall have handrails on is deficient practice ident evacuated DB lodge exit in the | K0038 | Facility contracted with a vend to install exterior handrails for ramp outside of 400 hall lodge exit. | ************************************* |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

4VNL21 Facility ID:

000522

If continuation sheet

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155479 | | | (X2) MULTIPLE CO A. BUILDING | ONSTRUCTION | (X3) DATE SURVEY COMPLETED 02/28/2011 |
|--------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------|---------------------------------------|
| | | 100479 | B. WING | ADDRESS, CITY, STATE, ZIP CODE | 02/20/2011 |
| NAME OF P | PROVIDER OR SUPPLIER | | I | / WASHINGTON CENTER ROA | D |
| | ON CARE CENTER | | | WAYNE, IN46825 | |
| (X4) ID PREFIX | | TATEMENT OF DEFICIENCIES | FULL PREFIX PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE | | (X5) |
| TAG | * | CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | | | COMPLETION DATE |
| | event of an em | | | | 2.112 |
| | Findings includ | e: | | | |
| | 1:30 p.m., the 4 discharge sides handrail on bot The ramp bega 400B lodge exithrough a ninet the pavement of Based on an in Operations Directors observation, he | rvation with the ector on 02/28/11 at 100B lodge exit walk/ramp lacked a h sides of the ramp. In at the landing of the t and continued by degree right turn to lift the parking lot. It terview with the ector at the time of e confirmed the rise g lot to the landing was | | | |
| K0067 SS=E | Based on obse the facility failed egress corridor as a portion of system/plenum heating and ver work serving ac 90A, the Stand of Air Condition Systems at 2-3 corridors shall in portion of a sup | rvation and interview, d to ensure 4 of 6 s were not being used a return air for air conditioning, ntilating (HVAC) duct djoining areas. NFPA ard for the Installation ing and Ventilation .11.1 requires egress not be used as a apply, return or exhaust ing adjoining areas. | K0067 | Kingston Care Center has requested and received a waiv for K067 at this location. Pleas refer to the enclosed documentation. | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155479 | | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE S | ETED |
|------------------------------------------------------------------------------------------------------------|----------------------|-------------------------------------------------|-----------------------------------------|--------|---------------------------------------------------------------------------------------------------------|-------------|------------|
| | | 155479 | B. WIN | G | | 02/28/20 | 011 |
| NAME OF P | PROVIDER OR SUPPLIER | | | | ADDRESS, CITY, STATE, ZIP CODE | _ | |
| KINGSTO | ON CARE CENTER | OF FORT WAYNE | | 1 | ' WASHINGTON CENTER ROA VAYNE, IN46825 | ND. | |
| (X4) ID | SUMMARY S | TATEMENT OF DEFICIENCIES | | ID | · | i | (X5) |
| PREFIX | | CY MUST BE PERCEDED BY FULL | | PREFIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | | COMPLETION |
| TAG | REGULATORY OR | LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCY) | IE. | DATE |
| | This deficient p | ractice could affect | | | | | |
| | | e 100, 200 and 300 | | | | | |
| | halls. | | | | | | |
| | Findings includ | e· | | | | | |
| | i mamgo molad | . | | | | | |
| | | rvation on 02/28/11 on | | | | | |
| | | cility from 11:40 a.m. to | | | | | |
| | 2:00 p.m. with t | - | | | | | |
| | | ident rooms and the | | | | | |
| | | with the exception of on the 400 wing, were | | | | | |
| | | s corridors as a return | | | | | |
| | | sed on an interview | | | | | |
| | | ions Director at the | | | | | |
| | time of observa | tion, the facility had | | | | | |
| | modified the H\ | _ | | | | | |
| | | e fire alarm system | | | | | |
| | | air fans. Additionally, | | | | | |
| | | ected to the air supply | | | | | |
| | | ed with duct detectors ream of the air filters, | | | | | |
| | | tivated, shut off supply | | | | | |
| | | nally, the HVAC ducts | | | | | |
| | | te any fire or smoke | | | | | |
| | • | iminating the need for | | | | | |
| | | of smoke dampers to | | | | | |
| | • | nsfer of smoke from | | | | | |
| | one smoke con | npartment to another. | | | | | |
| | 3.1-19(b) | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |

PRINTED: 04/05/2011 FORM APPROVED OMB NO. 0938-0391

| | T OF DEFICIENCIES OF CORRECTION | l ' | | | ONSTRUCTION | (X3) DATE: COMPL 02/28/2 | ETED |
|--------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----|---------------------|------------------------------------------------------------------------------------------------------------------------------------|--------------------------------|----------------------------|
| | ROVIDER OR SUPPLIER | | | 1010 W | ADDRESS, CITY, STATE, ZIP CODE / WASHINGTON CENTER ROA // WAYNE, IN46825 | ۸D | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | TE | (X5) COMPLETION DATE |
| K0144 SS=C | the facility failed emergency ger with a remote in 7.9.2.3 requires generators provemergency light installed, tested accordance with for Emergency Systems. NFP 3-5.5.6 requires shall have a restation of a type break-glass state room housi NFPA 37, Standard Use of State Engines and Gedition, at 8-2.2 of 100 horsepo provision for shat the engine a location. This caffect all occup Findings includ Based on obse Operations Directly during a tour of a.m. to 2:00 p.r. have a remote | viding power to ting systems shall be d and maintained in h NFPA 110, Standard and Standby Power A 110, 1999 edition, s Level II installations mote manual stop e similar to a tion located outside ng the prime mover. dard for the Installation tionary Combustion as Turbines, 1998 2(c) requires engines wer or more have sutting down the engine and from a remote deficient practice could ants. | KO | 144 | Facility contracted with a veno to install a remote manual sto for the emergency generator located outside of the generat | р | 03/30/2011 |
| | | | | | | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

4VNL21 Facility ID:

000522

If continuation sheet

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| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155479 | | | (X2) MULTIPLE CONSTRUCTION A. BUILDING D. WING (X3) DATE SUI COMPLET. 02/28/201 | | ETED | | |
|--------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|---------------|------------------------------------------------------------------------------------------------------------------------------|---|--------------------|
| | PROVIDER OR SUPPLIER | | B. WINC | STREET A | ADDRESS, CITY, STATE, ZIP CODE WASHINGTON CENTER ROA WAYNE, IN46825 | | |
| (X4) ID | SUMMARY S | TATEMENT OF DEFICIENCIES | \top | ID | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE | | (X5) |
| PREFIX TAG | ` | CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | | PREFIX TAG | CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) | E | COMPLETION DATE |
| | at 10:50 a.m. o generator was the motor is over | he Operations Director n 02/28/11, the installed in 2007 and er 100 horsepower. | | | | | |
| | 3-1.19(b) | | | | | | |
| SS=C | the facility failed emergency ger with a remote in 7.9.2.3 requires generators provemergency light installed, tested accordance with for Emergency Systems. NFP 3-5.5.6 requires shall have a restation of a type break-glass state room housi NFPA 37, Standand Use of Statengines and Gedition, at 8-2.2 of 100 horsepoprovision for shall the engine a | viding power to ting systems shall be d and maintained in h NFPA 110, Standard and Standby Power A 110, 1999 edition, s Level II installations mote manual stop | | | Facility contracted with a vend to install a remote manual stor for the emergency generator located outside of the generator |) | 03/30/2011 |

| | T OF DEFICIENCIES OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | ONSTRUCTION | (X3) DATE : COMPL | |
|---------------|-------------------------------------|----------------------------------------------------------|------------------|---------------|-----------------------------------------------------------------|----------------------|--------------------|
| | | 155479 | A. BUI B. WIN | LDING IG | | 02/28/2 | 011 |
| NAME OF F | DOLUBER OR GURRU ER | | D. "I | | ADDRESS, CITY, STATE, ZIP CODE | | |
| NAME OF F | PROVIDER OR SUPPLIER | | | 1010 W | WASHINGTON CENTER ROA | D | |
| KINGSTO | ON CARE CENTER | OF FORT WAYNE | | FORT V | WAYNE, IN46825 | | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE | | (X5) |
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| 1710 | affect all occup | | | 1110 | | | Ditte |
| | | | | | | | |
| | Findings includ | e: | | | | | |
| | Based on obse | rvation with the | | | | | |
| | | ector on 02/28/11 | | | | | |
| | • | the facility from 11:40 | | | | | |
| | _ | n., the facility did not | | | | | |
| | | manual stop for the | | | | | |
| | , , , | nerator. Based on an | | | | | |
| | | he Operations Director | | | | | |
| | at 10:50 a.m. o | | | | | | |
| | _ | installed in 2007 and er 100 horsepower. | | | | | |
| | | er 100 norsepower. | | | | | |
| | 3-1.19(b) | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | Based on observation and interview, | | İ | | Facility contracted with a vend | or | 03/30/2011 |
| SS=C | | d to ensure 1 of 1 | | | to install a remote manual stop | | 03/30/2011 |
| 33=C | | nerators was equipped | | | for the emergency generator | or | |
| | | nanual stop. LSC | | | located outside of the generate | JI. | |
| | 7.9.2.3 requires | | | | | | |
| | generators prov | • . | | | | | |
| | | ting systems shall be | | | | | |
| | • | d and maintained in | | | | | |
| | | h NFPA 110, Standard and Standby Power | | | | | |
| | , | A 110, 1999 edition, | | | | | |
| | • | s Level II installations | | | | | |
| | • | mote manual stop | | | | | |
| | station of a type | • | | | | | |
| FORM CMS-2 | 567(02-99) Previous Versio | ons Obsolete Event ID: | 4VNL21 | Facility | ID: 000522 If continuation sl | neet Pa | ge 8 of 16 |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE S | ETED | |
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| | | 155479 | B. WING | | | 02/28/2 | U11 |
| | PROVIDER OR SUPPLIER ON CARE CENTER | | STREET ADDRESS, CITY, STATE, ZIP CODE 1010 W WASHINGTON CENTER ROAD FORT WAYNE, IN46825 | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | P: | ID REFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) | ΓE | (X5) COMPLETION DATE |
| | the room housin NFPA 37, Standard Use of Star Engines and Garage Edition, at 8-2.2 of 100 horsepo provision for shat the engine at location. This caffect all occupations Directly of the engine at the engine at location. This caffect all occupations Directly of the engine at the engine at location. This caffect all occupations Directly of the engine at the engine a | e: rvation with the ector on 02/28/11 the facility from 11:40 n., the facility did not manual stop for the herator. Based on an he Operations Director | | | | | |
| SS=C | the facility failed emergency ger | rvation and interview, d to ensure 1 of 1 perators was equipped manual stop. LSC | | | Facility contracted with a vend to install a remote manual stop for the emergency generator located outside of the generate |) | 03/30/2011 |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155479 | | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | SURVEY ETED | |
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| | | 155479 | B. WIN | | | 02/28/2 | U11 |
| | PROVIDER OR SUPPLIER ON CARE CENTER | | | 1010 W | ADDRESS, CITY, STATE, ZIP CODE WASHINGTON CENTER ROA WAYNE, IN46825 | ΔD | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | TE | (X5) COMPLETION DATE |
| | installed, tested accordance with for Emergency Systems. NFP 3-5.5.6 requires shall have a restation of a type break-glass stathe room housi NFPA 37, Standand Use of Statengines and Gedition, at 8-2.2 of 100 horsepo provision for shat the engine a location. This caffect all occup Findings includ Based on obse Operations Directly during a tour of a.m. to 2:00 p.r. have a remote emergency ger interview with that 10:50 a.m. of generator was | viding power to ting systems shall be d and maintained in h NFPA 110, Standard and Standby Power A 110, 1999 edition, s Level II installations mote manual stop e similar to a tion located outside ng the prime mover. dard for the Installation tionary Combustion as Turbines, 1998 2(c) requires engines wer or more have utting down the engine nd from a remote deficient practice could ants. e: rvation with the ector on 02/28/11 the facility from 11:40 m., the facility did not manual stop for the nerator. Based on an the Operations Director | | | | | |

| | AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION | | | COMPL | |
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| | | 155479 | A. BU B. WI | ILDING NG | | 02/28/2 | |
| | ROVIDER OR SUPPLIER ON CARE CENTER | OF FORT WAYNE | 1 | STREET A | ADDRESS, CITY, STATE, ZIP CODE WASHINGTON CENTER ROA WAYNE, IN46825 | AD | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | TE | (X5) COMPLETION DATE |
| SS=C | the facility failed emergency genwith a remote in 7.9.2.3 requires generators provemergency light installed, tested accordance with for Emergency Systems. NFP 3-5.5.6 requires shall have a restation of a type break-glass state room housin NFPA 37, Standand Use of State Engines and Garagines and | viding power to ting systems shall be I and maintained in In NFPA 110, Standard and Standby Power I 110, 1999 edition, Is Level II installations mote manual stop e similar to a tion located outside ing the prime mover. Idard for the Installation cionary Combustion as Turbines, 1998 I(c) requires engines wer or more have utting down the engine and from a remote deficient practice could ants. | | | Facility contracted with a vence to install a remote manual stor for the emergency generator located outside of the generations. | р | 03/30/2011 |
| | | | | | | | |

| STATEMEN | T OF DEFICIENCIES | X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE CO | ONSTRUCTION | (X3) DATE SURVEY | |
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| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING | | COMPLETED | |
| | | 155479 | B. WING | | 02/28/2011 | |
| NAME OF I | PROVIDER OR SUPPLIER | 2 | | ADDRESS, CITY, STATE, ZIP CODE V WASHINGTON CENTER ROA | AD | |
| KINGSTO | ON CARE CENTER | OF FORT WAYNE | FORT | WAYNE, IN46825 | | |
| (X4) ID | SUMMARY S | TATEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF CORRECTION | (X5) | |
| PREFIX TAG | ` | CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | PREFIX TAG | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | TE COMPLETION DATE | |
| SS=C | Based on obsetoperations Directly during a tour of a.m. to 2:00 p.r. have a remote emergency gerinterview with that 10:50 a.m. of generator was the motor is over 3-1.19(b) Based on obseto the facility failed emergency gerwith a remote rower generators proved emergency light installed, tested accordance with for Emergency Systems. NFP 3-5.5.6 requires shall have a restation of a type break-glass state the room housi NFPA 37, Standand Use of State Engines and G | rvation with the ector on 02/28/11 f the facility from 11:40 m., the facility did not manual stop for the nerator. Based on an he Operations Director in 02/28/11, the installed in 2007 and er 100 horsepower. rvation and interview, d to ensure 1 of 1 nerators was equipped manual stop. LSC is emergency viding power to atting systems shall be d and maintained in the NFPA 110, Standard and Standby Power A 110, 1999 edition, is Level II installations mote manual stop. | | Facility contracted with a vence to install a remote manual sto for the emergency generator located outside of the generat | dor 03/30/2011 | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | IDENTIFICATION NUMBER: | | 2) MULTIPLE CONSTRUCTION BUILDING | | | (X3) DATE SURVEY COMPLETED | |
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| | | 155479 | B. WIN | | 02 | | 02/28/2011 | |
| NAME OF PROVIDER OR SUPPLIER KINGSTON CARE CENTER OF FORT WAYNE | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1010 W WASHINGTON CENTER ROAD FORT WAYNE, IN46825 | | | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | | ID PREFIX | PROVIDER'S PLAN OF CORRECTION | | | |
| IAU | of 100 horsepor provision for shat the engine at location. This caffect all occupations included Based on obseto operations Directly during a tour of a.m. to 2:00 p.m. have a remote emergency geninterview with that 10:50 a.m. or generator was in the state of the st | wer or more have utting down the engine and from a remote deficient practice could ants. e: rvation with the ector on 02/28/11 the facility from 11:40 an., the facility did not manual stop for the herator. Based on an ane Operations Director | | IAU | | | DATE | |
| SS=C | the facility failed emergency gen with a remote n 7.9.2.3 requires generators prov emergency ligh installed, tested accordance with for Emergency Systems. NFP | | | | Facility contracted with a vend to install a remote manual stop for the emergency generator located outside of the generate |) | 03/30/2011 | |

| STATEMENT OF DEFICIENCIES | | (X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE CONSTRUCTION | | NSTRUCTION | (X3) DATE SURVEY COMPLETED | |
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| AND PLAN OF CORRECTION | | IDENTIFICATION NUMBER: | A. BUILDING | | | | |
| | | 155479 | B. WING | B. WING | | 02/28/2011 | |
| NAME OF PROVIDER OR SUPPLIER | | | | | ADDRESS, CITY, STATE, ZIP CODE | _ | |
| KINGSTON CARE CENTER OF FORT WAYNE | | | 1010 W WASHINGTON CENTER ROAD FORT WAYNE, IN46825 | | | | |
| (X4) ID | (X4) ID SUMMARY STATEMENT OF DEFICIENCIES | | $\overline{}$ | ID | | | (X5) |
| PREFIX | | DEFICIENCY MUST BE PERCEDED BY FULL PREFIX | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE | | COMPLETION | |
| TAG | REGULATORY OR | LSC IDENTIFYING INFORMATION) | | TAG CROSS-REFERENCED TO THE APPROPR | | I C | DATE |
| | shall have a re | mote manual stop | Ī | | | | |
| | station of a type | e similar to a | | | | | |
| | break-glass sta | ation located outside | | | | | |
| | the room housi | ng the prime mover. | | | | | |
| | NFPA 37, Stan | dard for the Installation | | | | | |
| | and Use of Sta | tionary Combustion | | | | | |
| | | as Turbines, 1998 | | | | | |
| | _ | 2(c) requires engines | | | | | |
| | | wer or more have | | | | | |
| | - | nutting down the engine | | | | | |
| | - | nd from a remote | | | | | |
| | _ | deficient practice could | | | | | |
| | affect all occup | - | | | | | |
| | | | | | | | |
| | Findings includ | le: | | | | | |
| | - mamage motories | | | | | | |
| | Based on obse | rvation with the | | | | | |
| | Operations Dire | ector on 02/28/11 | | | | | |
| | during a tour of | f the facility from 11:40 | | | | | |
| | a.m. to 2:00 p.r | m., the facility did not | | | | | |
| | have a remote manual stop for the | | | | | | |
| | emergency generator. Based on an | | | | | | |
| | interview with the Operations Director | | | | | | |
| | at 10:50 a.m. on 02/28/11, the | | | | | | |
| | generator was installed in 2007 and | | | | | | |
| | the motor is over 100 horsepower. | | | | | | |
| | and motor to the newsperson | | | | | | |
| | 3-1.19(b) | | | | | | |
| | , | | | | | | |
| | | | | | | | |
| | Based on obse | ervation and interview, | | | Facility contracted with a vend | lor | 03/30/2011 |
| SS=C | | d to ensure 1 of 1 | | | to install a remote manual stop | | |
| 33-0 | emergency generators was equipped with a remote manual stop. LSC | | | | for the emergency generator | | |
| | | | | | located outside of the generate | or. | |
| | | | | | | | |

| | | XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155479 | A. BUILDIN | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | | (X3) DATE SURVEY COMPLETED 02/28/2011 | |
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| NAME OF PROVIDER OR SUPPLIER KINGSTON CARE CENTER OF FORT WAYNE | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1010 W WASHINGTON CENTER ROAD FORT WAYNE, IN46825 | | | | |
| (X4) ID PREFIX TAG | IX (EACH DEFICIENCY MUST BE PERCEDED BY FULL | | ID PREI TA | FIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) | (X5) COMPLETION DATE | |
| | installed, tested accordance with for Emergency Systems. NFP 3-5.5.6 requires shall have a reristation of a type break-glass stathe room housin NFPA 37, Standand Use of Statengines and Gedition, at 8-2.2 of 100 horsepo provision for shat the engine allocation. This caffect all occupations Directly of the provision of the accordance of the provision of the emergency generator was generator was signed as a constant of the provision of the provisi | viding power to ting systems shall be d and maintained in h NFPA 110, Standard and Standby Power A 110, 1999 edition, is Level II installations mote manual stop e similar to a tion located outside ing the prime mover. dard for the Installation tionary Combustion as Turbines, 1998 (2(c) requires engines wer or more have utting down the engine ind from a remote deficient practice could ants. e: rvation with the ector on 02/28/11 if the facility from 11:40 in., the facility did not manual stop for the iterator. Based on an ine Operations Director | | | | | |

| l I | | XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155479 | (X2) MULTIPLE C A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 02/28/2011 | | | |
|------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------|-------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------|----------------------|--|--|
| NAME OF PROVIDER OR SUPPLIER KINGSTON CARE CENTER OF FORT WAYNE | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1010 W WASHINGTON CENTER ROAD FORT WAYNE, IN46825 | | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY) | (X5) COMPLETION DATE | | |
| - | 3-1.19(b) | | | | | | |
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